Mental Health Series

Self-Mutilation as a Clinical Phenomenon

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INTRODUCTION

Self-mutilation refers to a set of symptoms with numerous associated psychiatric disturbances and proposed underlying etiologies. Characteristics of self-injury are "any sort of self-harm" involving injury or pain inflicted to oneself.[1] Self-mutilation is defined as a "behavior producing physical injury to the person's own body, regardless of apparent or supposed intent." Theories abound as to the underlying causes of these symptoms. Self-mutilation has primarily been viewed in the psychiatric literature as a localized self-destructiveness, with mishandling of aggressive impulses caused by a person's unconscious wish to cause pain to himself or those around him. One of the "benefits" of self-mutilative behavior, characteristically mentioned by these patients, is a reported "release of tension." This is difficult for family, friends and health care practitioners to understand, and is frequently interpreted as a hostile manipulation. In truth, the release of tension is experienced by the patient as a positive event which then reinforces the cycle of bad feeling followed by self-mutilation and then relief. Reports of naloxone blockade of this relief suggest an endorphin-mediated response, although treatment with naltrexone has not been shown to reduce the incidence of self-mutilation among chronic self-mutilators. As such, there is not a definitive description or theory of this behavior. Self-mutilation has even been described as "trying to create a sense of order out of chaos,"[2,3] thus reflecting an improvement in mood state that often accompanies this behavior.

Studies have shown that about 4% of all patients in psychiatric hospitals have cut themselves; the female-to-male ratio is almost 3 to 1. The incidence of self-injury in psychiatric patients is estimated to be more than 50 times greater than that in the general population. Self-mutilators generally become chronic in these behaviors over a period of years. Typical patients are in their 20s and may be single or married. Most cut delicately and purposefully, not coarsely. This is usually done in private with a razor blade, broken glass, or mirror. The most common areas of cutting are the wrists, arms, thighs, and legs. The face, breasts, and abdomen are rarely targeted. Most people who cut themselves claim to experience no pain and give reasons such as anger at themselves or others, the wish to die, and the aforementioned relief of tension. Alcohol abuse and other substance abuse are common, and the majority of self-mutilators have attempted suicide. There have been studies linking self-mutilation with mental illness and also with child sexual abuse.[4] In fact, a clinical survey in 1999 found that "childhood sexual abuse status was linked strongly to adult self-destructiveness, as was early exposure to maternal indifference."[5]

In a recent study, there was evidence of more self-destructive behaviors, more personality dysfunction, and more overall adversity in children who had been sexually abused. These children were also more likely to be self-destructive as adults.[6] In fact, sexual abuse is considered an important risk factor for a variety of later problems in life. Children who have been sexually abused are at a greater risk for anxiety, depression, posttraumatic stress disorder, and other mental disorders.[7] The following court case illustrates the impact on individuals, the court system, as well as healthcare providers.

TENNESSEE CASE STUDY

Morris v Morris, 783 So. 2d 681 (Miss. 2001). J (husband) and S (wife) were married on August 8, 1981, in Tennessee. During December 1998, they separated while living in Mississippi. On January 18, 1999, J filed for divorce. On September 22, 1999, the court entered a decree of divorce in favor of J. The court granted sole legal and physical custody of the minor children, on the grounds of habitual cruel and inhuman treatment.

S appealed, arguing that the court: (1) had not allowed her to submit expert testimony of her mental state from a licensed social worker in Tennessee. This licensed social worker, H, had been S's therapist from 1996 until the time of the appeal. S felt H could give expert testimony, whereby the counter charge of cruel and inhuman treatment charged by S from J would have been validated; (2) was biased because S was involved with an extramarital relationship, and (3) had erred in their determination that granting custody to S was not in the best interest of the children.

Upon appeal, the court responded as follows: S had self-mutilated in the presence of her husband and children in the home. In addition, she had a medical history of blackouts, paranoia, and hallucinations, with reported urges to throw her son over the balcony. She also admitted to making threats to kill her husband and mother. The court struggled with whether custody of the children with their mother would be in the best interest of the health and well-being of her children. She had not submitted the name of the social worker as an expert in the initial discovery of the trial, and therefore, the testimony of the social worker was

rejected. Finally, S was living with her partner, which resulted in the court concluding that she was involved in an extramarital affair.

The court was "disturbed" with the fact that S had cut herself in the presence of her children. The court indicated that it was clear from the testimony that much of her emotional problems stemmed from her childhood sexual abuse by her grandfather from the age of 8 to 12. They also noted that there was a history of violence, and that S had difficulty with her relationship with her husband during the marriage. Throughout this marriage, J incurred significant medical bills for her mental and emotional problems. This debt resulted in J's filing for bankruptcy. After a full consideration of all the available facts, the court affirmed the divorce and custody of the children to J.[8]

CONCLUSION

Clinical lore is replete with the association of self-mutilation and child abuse in general. In addition, there are studies that have shown an association between self-mutilation and reported histories of child sexual abuse. Increased awareness and publicity regarding this symptom cluster may be responsible for the increasing incidence noted among patients with significant psychiatric difficulties. However, self-destructive behavior as a whole is poorly understood, difficult to treat, and associated with a high degree of associated psychosocial morbidity. The literature addressing this phenomenon is largely based on heterogeneous groups of self-injurers that include patients with psychotic disorders, mental retardation, organic mental disorders, and various personality disorders.[3,9]

Treatment generally focuses on the underlying mental illness with the expectation that the self-injurious behaviors will improve. Many times the self-injurious behavior resulting from sexual abuse continues through adulthood and presents unique problems for courts, physicians, and families. It is important to understand these motivations and intentions of the self-harmer. Empathy is an important tool in working with these patients.[2] Because the treatment programs must by necessity be individualized, there are no specific treatments at this point, shown to be useful in all cases. As such, early identification, treatment, and additional research studies are needed to provide a systematic framework to guide clinical decision-making for these severely disturbed patients, leading to better outcomes and ultimately sounder clinical policies. In addition, patient education is essential in ensuring positive therapeutic outcomes.[3,6] ■

References

1. Simpson C, Self-Mutilation. ERIC/CASS Digest [ERIC Clearinghouse on Counseling and Student Services Greensboro NC] ED465945 2001-12-00.

2. Clarke L, Whittaker: Self-mutilation: culture, contests and nursing response. J Clin Nurs 7:129-137, 1998.

3. Kaplan H, Sadock B: Synopsis of Psychiatry, ed 8. New York, NY, Williams & Wilkins, 1997.

4. Romans SE, Martin JL, Anderson JC: Sexual abuse in childhood and deliberate self-harm. Am J Psychiatry 152:1336-1342, 1995.

5. Gladstone G, Parker T, et al: Characteristics of depressed patients who report childhood sexual abuse. Am J Psychiatry 156:432-437, 1999.

6. Klonsky ED, Oltmanns TF, Turkheimer E: Deliberate self-harm in a nonclinical population: prevalence and psychological correlates. Am J Psychiatry 160:1501-1508, 2003.

7. Wiener JM, Textbook of Child and Adolescent Psychiatry, ed 2. Washington, DC, American Psychiatric Press. 1997.

8. Morris v Morris, 783 So. 2d 681 (Miss, 2001).

9. Dubo ED, Zanarini MC, Lewis RE, et al: Childhood antecedents of self-destructiveness in borderline personality disorder. Canad J Psychiatry. 42:63-69, 1997.

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